*Massachusetts Division of Health Care Finance and Policy*

# An Evaluation of Health Care Programs for Low Income Uninsured and Underinsured Massachusetts Residents

## Chapter 1: The Children's Medical Security Plan

A Report to the Senate Committee on Ways and Means,
House Committee on Ways and Means
and Joint Committee on Health Care

June 2000

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**An Evaluation of Programs for Low Income Uninsured and Underinsured Massachusetts Residents**
**Chapter 1: The Children's Medical Security Plan**



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**Executive Summary**

In March 1998, the Division of Health Care Finance and Policy submitted a report to the legislature entitled *An Evaluation of Health Care Programs for Low Income Uninsured and Underinsured Massachusetts Residents*. That report evaluated four programs:

- MassHealth
- The Children's Medical Security Plan
- The Senior Pharmacy Assistance Program and
- The Uncompensated Care Pool

This report is an update on one of those programs—the Children's Medical Security Plan. The Children's Medical Security Plan (CMSP) is a health insurance program administered by the Massachusetts Department of Public Health (DPH) that provides limited coverage for primary and preventive health care for children under age 19. Major findings of this report include:

- As of March 2000, CMSP increased benefits for pharmacy, durable medical equipment and mental health services. Additionally, DPH implemented a primary and preventive dental benefit in May 2000.

- From July 1997 to June 1999, DPH in coordination with DMA successfully transferred approximately 29,000 children from CMSP to MassHealth.

- From 1997 to 1999 the percentage of children with family income under 200% of the Federal Poverty Level (FPL) decreased from 83% to 34% of total enrollees. The percentage of children with family income between 200% and 400% FPL increased from 17% to 64%.

- Ninety-five percent of families on CMSP are employed, a slight increase from the 1998 report.

- CMSP is experiencing a tremendous amount of turnover in its enrolled population. During the six-month period ending December 1999, 8,266 children enrolled in CMSP and 9,720 children disenrolled.

- Due to the increase in the number of children from families with income greater than 200% FPL, premiums paid by enrollees have increased from 4% to 8% of total program expenditures.

- The per member per month cost has decreased from $42.51 per member per month in fiscal year 1997 to $37.24 per member per month in fiscal year 1999.

- DPH is currently implementing a study looking at the impact of premiums, the availability of employer-sponsored health insurance and dental health benefits and the

impact of other state sponsored health insurance and safety net programs on CMSP enrollment and disenrollment.

Recommendations for the future include monitoring the implementation of the additional benefits, gathering more data in order to understand the population currently served by CMSP and continuing to improve coordination efforts with the Division of Medical Assistance.

## Section 1: Introduction

This report on the Children's Medical Security Plan (CMSP) is part of the Division of Health Care Finance and Policy's (DHCFP) second assessment of the health reform initiatives mandated by Section 17 of Chapter 47 of the Acts of 1997, An Act Assisting in Making Health Care Available to Low Income Uninsured and Underinsured Residents of the Commonwealth. This statute requires the Division of Health Care Finance and Policy to assess the MassHealth Program, the Senior Pharmacy Assistance Program, the Children's Medical Security Plan and the Uncompensated Care Pool. This report is the first in a series of reports that succeed the Division's March 1998 report, *An Evaluation of Health Care Programs for Low Income Uninsured and Underinsured Massachusetts Residents*.

This report provides a brief description of the Children's Medical Security Plan focusing primarily on eligibility requirements and benefits offered. It includes sections on enrollment trends, service utilization, costs and program operations. The analysis presented in this report is based primarily on enrollment, utilization and fiscal data provided by the Department of Public Health and its current program administrator, Unicare. Through December of 1997, CMSP offered services through a second plan administrator named Community Health Plan (CHP). Where possible, enrollment and cost data for CHP is included. For fiscal years 1997 and 1998, Unicare accounted for somewhat more than 90% of total CMSP enrollment and expenditures. An independent consultant obtained qualitative data through interviews with program personnel and key stakeholders (see Appendix I for a list of interviewees).

**Section 2: Program Description**

The Children's Medical Security Plan (CMSP) is a health insurance program that provides limited coverage for primary and preventive health care for children under age 19.[*] It is administered by the Massachusetts Department of Public Health. CMSP is funded entirely by state funds. Its fiscal year 2000 appropriation is $13,658,855.

The CMSP benefit package currently includes:

- routine well-child check-ups
- immunizations
- doctor office visits
- specialty consultations
- 13 mental health and substance abuse visits, with an additional 7 visits if clinically necessary
- up to $1000 for emergency care
- limited outpatient surgery[1]
- lab tests, x-rays and other diagnostic tests
- durable medical equipment (DME) up to $200 a year per child (this includes eyeglasses and hearing aids); the benefit increases to $500 for DME related to asthma, diabetes and seizure disorders
- prescription medicine up to $200 per child per year
- primary and preventive dental benefits

All children under the age of 19 are eligible for CMSP, provided they are not eligible for MassHealth (except for MassHealth Limited) and do not have other health insurance coverage with primary and preventive medical benefits. Children whose family income (see Appendix II for federal poverty level guidelines) is less than or equal to 200% FPL (currently $34,100 for a family of 4) participate in CMSP free of charge. Families with income between 200% and 400% FPL contribute $10.50 per child per month with a maximum family contribution of $31.50 per month. Families with income greater than 400% FPL (currently $68,200 for a family of 4) contribute the full premium amount of $52.50 per child per month.

The Department of Public Health currently contracts with a private entity, Unicare, to provide administrative services such as claims processing, customer service, premium collection, and utilization management. Participants in CMSP are encouraged to receive care provided by providers that participate in Unicare's CMSP network of physician groups, community health centers and hospitals. In 1999, CMSP members had access to over 7500 network providers. In-network providers are paid according to pre-established rates set by selected federal and state regulations for other programs; in addition, some rates for particular services are negotiated.[2] Out-of-network providers are generally paid at 80% of the negotiated rate. CMSP participants are responsible for co-payments of $1 – $5 depending on their income level as well as the particular service received. No co-payments are required for preventive (well child) visits.

[*] See Appendix III for a legislative and administrative history

**Section 3: Enrollment Trends**

*General Enrollment Trends/Transfer of Enrollees to MassHealth*[3]

Changes and shifts in CMSP enrollment since health reform began have been directly correlated to the MassHealth Expansion. The MassHealth Expansion was implemented in two phases.[4]Phase 1—the MassHealth Section 1115 Waiver—was implemented in July 1997. This waiver increased the income eligibility criteria for all children under age 19 to 133% FPL. Phase 2—The MassHealth Demonstration Project—was implemented in July 1998. The MassHealth Demonstration Project increased income eligibility criteria for all children under age 19 to 200% FPL. The expected impact of these expansions upon CMSP was that children traditionally enrolled in CMSP would now be eligible for MassHealth, thus reducing total demand for the CMSP program.

Table 1 describes enrollment activity for CMSP from June 1997 through December 1999. From June 1997 to June 1998, CMSP enrollment increased from 34,832 to 41,114. Expanded outreach activities as well as a simpler enrollment process accounted for this overall enrollment increase. During this same time period, which corresponds to Phase I of the MassHealth Expansion, DPH transferred 9,580 children to MassHealth.

## Table 1: Active Enrollment at Quarter End June 1997 - December 1999

| Month | Active Enrollment |
|---|---|
| June 1997* | 34,832 |
| Sept. 1997 | 39,737 |
| Dec. 1997 | 45,095 |
| March 1998 | 44,803 |
| June 1998 | 41,114 |
| Sept. 1998 | 27,923 |
| Dec. 1998 | 23,952 |
| March 1999 | 21,274 |
| June 1999 | 19,889 |
| Sept. 1999 | 17,801 |
| Dec. 1999 | 18,445 |
| March 2000 | 21,657 |

*June, September and December 1997 enrollment figures include CHP enrollment figures

From June 1998 to June 1999, enrollment decreased from 41,114 to 19,889. This time period corresponds to the implementation of Phase 2 of the MassHealth Expansion which increased eligibility for children for MassHealth to 200% FPL. Between June 1998 and September 1998, 10,291 children were transferred to MassHealth. Between October 1998 and June 1999

an additional 9,320 children were transferred to MassHealth. In all, 29,191 children were transferred from CMSP to MassHealth during fiscal years 1998 and 1999.

During the six months ending in December 1999, 8,266 children enrolled in and 9,720 children disenrolled from the Children's Medical Security Plan. These numbers indicate a sizeable turnover rate. DPH administrators have identified several possible causes including retroactive enrollment into MassHealth and non-payment of premiums by families initially enrolled into CMSP. More research needs to be done as to why this high level of turnover, often referred to as churning, is occurring and what implications it has for the structure of the program.

*Enrollment by Income*[5]

In Table 2 the total number of children enrolled by income category between October 1997 and December 1999 is displayed. As was the goal of health reform, the demographics of the population served by CMSP changed significantly. From October 1997 to December 1999, the number of CMSP children whose family income was between 200% FPL and 400% FPL increased from 17% to 64%. From October 1997 to December 1999 the number of CMSP children whose family income was under 200% decreased from 83% to 34%. Of the 6,259 children under 200% remaining enrolled in CMSP approximately 3,800[6] are concurrently enrolled in MassHealth Limited. MassHealth Limited offers emergency medical care for immigrants who are not categorically eligible for more comprehensive benefits. This large proportion of children enrolled in MassHealth Limited suggests that a majority of children enrolled in CMSP in the under 200% FPL category are from families whose immigration status does not allow them to enroll in a more comprehensive MassHealth program.[7]

## Table 2: Percent Enrolled by Income Category

| | October 1997 | June 1998 | June 1999 | December 1999 |
|---|---|---|---|---|
| **TOTAL** | 39,107* | 41,114 | 19,889 | 18,445 |
| **< 133% FPL** | 39% | 27% | 22% | 27% |
| **134%- 200% FPL** | 44% | 51% | 17% | 7% |
| **200%-400% FPL** | 17% | 22% | 59% | 64% |
| **> 400% FPL** | 0% | 0%** | 2% | 2% |

* Does not include enrollees in CHP

** In June 98, there were 327 children in the over 400% category. Because of the large total number this came to 0%. In June 99, there were 329 children in this category and in December 1999 there were 336.

*Enrollment by Age*[8]

Table 3 shows the percentage of children enrolled by age. Just prior to the first time period shown in this table, eligibility for CMSP was expanded to include children between the ages of 13 and 18. In June 1997, 78% of children enrolled were between the ages of 0 and 12 and 22% were between the ages of 13 and 18. As of December 1999, 32% of children enrolled were between the ages of 13 and 18. For purposes of comparison, according to the 1990 U.S. Census, children between the ages of 13 and 18 in Massachusetts accounted for 30% of all children ages 0-18.

## Table 3: Percent Enrolled By Age

| | June 1997 | June 1998 | June 1999 | December 1999 |
|---|---|---|---|---|
| **Total Number Enrolled** | 30,091* | 41,114 | 19,889 | 18,445 |
| **0-12** | 78% | 75% | 71% | 68% |
| **13-18** | 22% | 25% | 29% | 32% |

*Does not include limited authorization enrollees; Does not include enrollees in CHP

*Enrollment by Race and First Language Other than English*[9]

In 1997, CMSP collected information both on beneficiary race and first language spoken at home. This information was collected on a voluntary basis. In June 1997, 55% of applicants reported their race and 81% of applicants reported first language spoken at home. More recently, with the implementation of the joint application process with MassHealth, information on race and first language has not been available to CMSP administrators. DPH and DMA are currently working together to ensure the transfer of this information to CMSP administrators.

*Enrollment by Employment Status*[10]

Table 4 shows the percentage of families participating in CMSP who are employed. The number of employed families increased from 89% in June 1997 to 95% in December 1999. One concern that often arises when public programs offer insurance to employed persons is whether crowd-out occurs. Crowd-out refers to employers choosing not to provide health insurance to employees if they know employees have access to public health insurance, as well as to employees choosing to enroll in public programs rather than employer-sponsored plans because of the lesser expense of public programs. It is not clear whether the increase in the proportion of CMSP families who are employed is due to crowd-out since other factors besides the existence of a public program contribute to both employers' decisions to offer health insurance and an individual's decision to purchase it.

## Table 4: Percent of Families Who Are Employed*

| | June 1997 | June 1998 | June 1999 | December 1999 |
|---|---|---|---|---|
| **Total Number of Families** | 17,429 | 23,533 | 13,018 | 12,456 |
| **% Families Employed** | 89% | 91% | 93% | 95% |

*Does not include limited authorization enrollees; Does not include families with children enrolled in CHP

**Section 4: Service Utilization**

*Percentage of total claims dollars spent by age*[11]

Table 5 shows the total amount of dollars spent on CMSP claims by age group. For this analysis, data was only available from CMSP's current administrator, Unicare. Medical claims dollars paid by Unicare accounted for at least 90% of total claims dollars paid in both fiscal years 1997 and 1998. In fiscal year 1997, 14% of total CMSP claims dollars was spent on children ages 13-18. By 1999, 29% of total claims dollars were spent on children ages 13-18. Given that the program first opened to children ages 13-18 in fiscal year 1997, the increase in use may reflect the initial time it took for this age group to actually enroll in the program and begin using services.

## Table 5: Percent Claims Dollars Spent by Age Group, FY97-99

| | FY97 | FY98 | FY99 |
|---|---|---|---|
| **Total $ Spent, 0-18** | $9,432,021 | $16,368,518 | $8,260,727 |
| **Percent $ Spent, 0-12** | 86% | 73% | 71% |
| **Percent $ Spent, 13-18** | 14% | 27% | 29% |

Dollars and percentages based on Unicare data only.

*Utilization by benefit category*[12]

Tables 6 and 7 highlight the distribution of claims dollars by benefit categories. For this analysis, data was only available from CMSP's current administrator, Unicare. Medical claims dollars paid by Unicare accounted for at least 90% of total claims dollars paid in both fiscal years 1997 and 1998. In 1999, claims dollars for both age groups were spent primarily on sick visits, emergency visits, preventive visits and mental health visits. Children ages 0-12 spent a larger percentage of dollars on preventive care than did children ages 13-18. Children ages 13-18 spent a larger percentage of dollars on mental health benefits than did children ages 0-12.

Over time dollars spent for preventive care increased more for children ages 0-12 than for children ages 13-18. From 1997 to 1999, both groups increased their use of the eye exam and DME benefits. Pharmacy usage more than doubled for both groups. Additionally, while use of the mental health benefit increased for both groups, children ages 13-18 increased their use of this benefit by 55% whereas children ages 0-12 increased their use by 33%. Over time both groups use of radiology services decreased.

# Table 6: Percent Claims Dollars Spent by Service Category, Ages 0-12, FY97-99

| | 1997 | 1998 | 1999 |
|---|---|---|---|
| **Total $ spent, 0-12** | $8,112,280 | $11,965,179 | $5,848,925 |
| **Preventive** | 9% | 10% | 12% |
| **Sick** | 41% | 39% | 35% |
| **Emergency** | 20% | 20% | 21% |
| **Outpatient surgery** | 7% | 6% | 6% |
| **Mental health** | 6% | 6% | 8% |
| **Pharmacy** | 3% | 5% | 7% |
| **Eye exam** | 0% | 1% | 1% |
| **DME** | 1% | 1% | 2% |
| **Radiology** | 6% | 5% | 3% |
| **Laboratory** | 8% | 7% | 6% |

Dollars and percentages based on Unicare data only. Due to rounding numbers may not equal 100%.

# Table 7: Percent Claims Dollars Spent by Service Category, Ages 13-18, FY97-99

| | 1997 | 1998 | 1999 |
|---|---|---|---|
| **Total $ spent, 13-18** | $1,319,741 | $4,403,339 | $2,411,802 |
| **Preventive** | 6% | 5% | 7% |
| **Sick** | 30% | 30% | 28% |
| **Emergency** | 30% | 24% | 24% |
| **Outpatient Surgery** | 4% | 5% | 4% |
| **Mental health** | 9% | 11% | 14% |
| **Pharmacy** | 3% | 5% | 7% |
| **Eye exam** | 1% | 1% | 2% |
| **DME** | 1% | 2% | 3% |
| **Radiology** | 10% | 8% | 5% |
| **Laboratory** | 8% | 9% | 7% |

Dollars and percentages based on Unicare data only. Due to rounding numbers may not equal 100%.

**Section 5: Costs**

*Expenditures*[13]

Table 8 compares the total amount appropriated to the total amount expended for CMSP for each fiscal year 1995 through 1999. The large increase in total appropriations and expenditures in fiscal year 1998 reflects an interagency transfer of funds from DMA to DPH. This transfer of funds, mandated by the legislature, allowed CMSP to maintain children in its program who otherwise might have been disenrolled because of incomplete applications. Recognizing that many of these children would qualify for MassHealth under the new eligibility criteria, it was thought best to continue to provide services to them through CMSP until transferred to MassHealth. As can be seen from the table, the program stayed well within budget for each of the six years.

## Table 8: Appropriations versus Expenditures, FY95-99

| Fiscal Year | Total Appropriation | Total Expenditures* |
|---|---|---|
| 1995 | $12,000,000 | $ 9,927,647 |
| 1996 | $14,000,000 | $ 8,580,341 |
| 1997 | $14,307,926 | $13,345,476 |
| 1998 | $25,175,314 | $22,553,661 |
| 1999 | $13,718,248 | $12,063,190 |

*Includes amounts expended on CHP as well as on Unicare.

*Premiums billed to Enrollees*[14]

Table 9 shows that as the number of children in the 200%-400% FPL income group increased, the amount of premiums billed to enrollees increased. In fiscal year 1997, total premiums billed were 4% of total program expenditures. By fiscal year 1999, total premiums billed were 8% of total program expenditures. In 1997, Unicare estimated that 96% of the premiums billed were collected. The amount collected by Unicare is deposited into a general account known as the Health Access Fund. It is not returned directly to the CMSP program.

## Table 9: Premiums Billed to Enrollees, FY97-99 and Six Months Ending December 1999

| | FY97 | FY98 | FY99 | 6 months ending December 99 |
|---|---|---|---|---|
| **Premiums billed to enrollees for 200%-400%FPL** | $442,928 | $810,640 | $ 997,007 | $608,053 |
| **400% + percent** | $ 44,457 | $ 19,025 | $ 13,327 | $ 3,034 |
| **TOTAL** | $487,385 | $829,665 | $1,010,334 | $611,087 |

*Per member per month costs*[15]

Table 10 lists the per member per month (PMPM) costs for CMSP for fiscal years 1997 through 1999. Costs have decreased from $42.51 PMPM in fiscal year 1997 to $37.24 PMPM in fiscal year 1999.[16]

DPH calculates that as of May 2000 the cost will be $57.52 PMPM. This increased amount will allow for an increase in administrative fees, the provision of expanded prescription, mental health and DME benefits and the implementation of primary and preventive dental benefits. The cost of dental care alone is anticipated to be approximately $12.96 PMPM.

## Table 10: Per Member Per Month Costs, FY97-99

| | Total Per Member Per Month Costs |
|---|---|
| **FY97** | $42.51 |
| **FY98** | $42.89 |
| **FY99** | $37.24 |

*Administrative Costs*

Through May 2000, CMSP paid Unicare $10.09[17] per member per month for administrative services. As of May 2000, this amount was increased to $13.25 per member per month of which $1.50 PMPM is for administrative services associated with medical expenses other than dental, and $1.66 PMPM is for administrative services associated with the dental benefit. Administrative services include claims processing, customer service, premium collection, utilization management and network maintenance. The new administrative services fee is 23% of the projected $57.52 PMPM cost.

## Section 6: Program Operations

*Transfer of enrollees from CMSP to MassHealth*

According to individuals interviewed for this report, shortly after health reform was implemented, the Massachusetts Department of Public Health (DPH) began to transfer eligible children from the state funded Children's Medical Security Plan (CMSP) to MassHealth. Department efforts focused on individuals with incomes less than 133% FPL. After health reform, individuals were not eligible for CMSP unless they had applied for and been denied eligibility for MassHealth, using the MassHealth Benefits Request (MBR) application form. Most stakeholders reported that there have been no issues with regard to integrating CMSP into MassHealth.

Interviewees reported that several strategies were implemented to facilitate the transfer of eligible children from CMSP to MassHealth. For example, between March and September 1998, DPH launched a telephone campaign to facilitate the transfer of MassHealth eligible CMSP members to MassHealth. Workers would help individuals complete the MBR over the phone and then would mail the MBR to the individual for signing. Almost all relevant languages were available to individuals during this process. After all the people with incomes at 133% FPL or less were called, DPH began to call people with incomes between 134% and 200% FPL. During this time, all people interested in CMSP were required to complete an MBR before they could receive any services. Program administrators discontinued the previous practice of direct enrollment in the program in provider offices. CMSP also ran computer matches to see if any CMSP children were also eligible for health insurance from another source. Some people were in fact eligible and were directed to these insurances.

Stakeholders indicated that one exception to this process was the individual whose immigration status was that of "non-qualified alien."[18] These individuals could call regional offices directly and be enrolled in CMSP either on site or over the telephone. The MBR was sent directly to the claims payer, Unicare, for immediate enrollment. Only individuals who upon screening were not determined to be eligible for other MassHealth programs were allowed to participate in this process. Individuals preferred this approach if they were concerned about the "public charge" issue. Some outreach and eligibility workers were cautioning immigrants not to become a public charge, and so immigrants were afraid to enroll in CMSP or other programs. Stakeholders suggested that immigrants might still be inhibited from enrolling in CMSP because of the public charge issue and because of the complexity of completing the MBR.

*Identification of core population*

An important issue for CMSP is that it is difficult to identify a stable population in order to get a better sense of the costs of the group. CMSP leaders would like to implement more quality improvement goals, but this is a challenge because of the churning experienced by the program's population. One of the program's initiatives will be to learn more about the characteristics of the over 200% FPL population and try to understand why there is so much

churning in the population. One idea to further this goal**,** offered by an interviewee, would be to merge CMSP and Pool data to see if there is overlap in the population that uses these two programs. Also, in an effort to better understand the high rate of turnover, DPH is currently implementing a phone survey to measure the impact of premium cost, the availability and affordability of employer-sponsored health insurance and the addition of the expanded benefits on each family's decision to enroll or disenroll their child (ren) in CMSP.

*Continued integration and coordination with MassHealth*

Interview results suggest that some outreach workers do not encounter CMSP any longer because so many people are being enrolled in MassHealth. And, although one respondent suggested that "people are resistant to CMSP," most respondents believed that the integration between the programs has been extremely smooth: "there have been no issues with regard to integrating CMSP into MassHealth" and "DPH has kept enrollment of children into CMSP a high priority." As one respondent suggested, "most of the major issues related to CMSP have been resolved at this point."

Interviewees said that when the process of transferring children from CMSP to MassHealth was initiated, the transfer of information about eligibility between DMA and CMSP was cumbersome. Now, DPH receives a daily report from MassHealth about people who have been denied enrollment, so that the applicant can then apply for CMSP. CMSP and DMA continue to work together to get individuals enrolled in MassHealth as appropriate. For example, DMA will grant presumptive eligibility to individuals who appear to be eligible for MassHealth or CMSP. Those ineligible for MassHealth can contact a regional office for 45-day, temporary enrollment in CMSP if there is an immediate need to see a provider. One issue remaining to be resolved is how to accurately determine whether applicants who appear to be over 200% FPL are actually over or under 200% FPL. CMSP program administrators have found that many applicants denied enrollment by MassHealth because they are over 200% FPL are actually found be under 200% FPL once a more in depth look is taken at their income. The current mechanism for transferring enrollment information to DPH does not include information specifying whether income supporting documents have been provided. The new CMSP eligibility file will contain this information. When this is implemented, CMSP will defer eligibility decisions on individuals who have not provided all appropriate documentation and request that the information be submitted to DMA for redetermination of MassHealth and, if applicable, referral to CMSP for enrollment.

*Unicare Contract*

Interviewees reported that the relationship with Unicare as claims processor is going well. In addition to providing claims processing and network management activities, Unicare also provides customer service, enrollment, marketing, outreach and education activities. DPH was going to reprocure this contract but decided that the immediate implementation of the expanded benefits, specifically the primary and preventive dental benefit, necessitated the

extension of the Unicare contract through June 2001. DPH administrators feel that Unicare has been very receptive to the many changes that have occurred in this program.

*Provider Issues*

CMSP provider payment rates are based on the Resource Based Relative Value Scale (RBRVS) and as such exceed normal Medicaid payment rates. For the most part, providers seem happy with the program. One issue that has come up is a restriction in the legislation that prevents CMSP from paying for previous year's claims out of the current year's budget. Late claims are thus denied. Program managers would like this restriction removed. A second issue mentioned by program managers is that they would like to make sure providers actually bill CMSP for services provided to CMSP enrollees. In some instances it appears that providers may be billing the Uncompensated Care Pool instead of CMSP.

*Focus on Managed Care Aspect*

Legislation mandates that CMSP be a managed care program.[19] Currently, it qualifies as a managed care program primarily because enrollees have access to a network of providers maintained by Unicare. CMSP administrators would like to improve the "managed" component by making sure all enrollees are assigned a primary care physician and by following up with enrollees to make sure they are utilizing preventive care services particularly immunizations.

*Tracking Disenrollment*

CMSP administrators would like to improve procedures to determine the reasons why a person actually disenrolls, specifically whether or not a person becomes newly eligible for an employer-sponsored health insurance plan. The phone survey (see page 13) will identify factors affecting disenrollment and enable DPH to implement necessary procedural and policy decisions.

## Section 7: Program Impact

The legislation mandating the Chapter 47 Evaluation Project requires that the impact of each program be estimated on:

1) the rate of uninsurance;
2) the proportion of beneficiaries previously insured and previously uninsured;
3) the extent to which the program has influenced the provision of health care coverage by employers; and
4) the health of the residents of the Commonwealth.

In general, both the decrease and the shift in the population served by CMSP are direct and expected results of the recent Massachusetts health reform efforts. However, since the Children's Medical Security Plan is an integral component of a comprehensive, statewide health care reform effort, its impact on each of the above four areas can only be examined in the context of data collected from the other health care reform efforts, particularly the MassHealth Expansion. This will be done in more detail in the final chapter of the Chapter 47 Evaluation Series when data on all four programs has been collected and analyzed.

## Section 8: Summary and Next Steps

CMSP has successfully accomplished its short-term goal of transferring almost 30,000 children to MassHealth. CMSP program administrators now have the opportunity to focus more directly on the CMSP program itself. One of the major tasks of CMSP program administrators will be to monitor the implementation of the newly offered benefits, particularly the primary and preventive dental benefits. A second important task will be to achieve a better understanding of the current population enrolled in CMSP. Improved collection of data on employment patterns, race, and ethnicity as well as information about disenrollment patterns will aid in the performance of this task. Understanding the demographics and behaviors of the current population will permit program administrators to better target outreach efforts and benefits offered. It will also result in a better understanding of the churning issue which, in turn, will allow for design changes that emphasize continuity of care. Lastly, CMSP program administrators are encouraged to continue improving coordination efforts with the Division of Medical Assistance. Some specific areas that might be addressed include eligibility determination and the sharing of demographic and other family and applicant information.

## Appendix I: List of Interviewees

Judy Allonby, Division of Health Care Finance and Policy
Frances Anthes, Family Health
Ron Villanueva-Autry, Department of Public Health
Tom Barker, Massachusetts Hospital Association
Christine Ballas, Division of Health Care Finance and Policy
Mary Byrnes, Division of Health Care Finance and Policy
Pat Canney, Division of Medical Assistance
Bob Cooper, Cambridge Hospital
Charlene DeLoach, Joint Committee on Health Care, Massachusetts Legislature
Pat Edraos, Massachusetts League of Community Health Centers
Barbara Farrell, Baystate Health Systems
Robin Frost, Massachusetts Coalition for the Homeless
Charles Joffe-Halpern, EcuHealth Care
Marcia Hams, Health Care for All
Jim Hooley, Neighborhood Health Plan
Sarah Kerr Iselin, Massachusetts Hospital Association
Joe Kirkpatrick, Massachusetts Hospital Association
Katharine London, Division of Health Care Finance and Policy
Todd Maio, Department of Transitional Assistance
Paul Matthews, Joint Committee on Health Care, Massachusetts Legislature
Tammy O'Donnell, Neighborhood Health Plan
Scott Penn, Outer Cape Health Services
Marc Reynolds, Division of Medical Assistance
Ann Scannell, Division of Medical Assistance
Tom Traylor, Boston Medical Center
Geoff Wilkerson, Massachusetts Senior Action Council
Kate Willrich, Division of Medical Assistance

**Appendix II: Federal Poverty Levels**

*A. Division of Medical Assistance (DMA) - Monthly Income Guidelines*
*2000 Federal Poverty Income Guidelines for MassHealth*

The Division of Medical Assistance compares a family's monthly income (before taxes or other deductions) to the applicable federal poverty income guidelines in the chart below. If income is received on a weekly basis, DMA multiplies the weekly income by 4 1/3 to calculate a monthly amount.

*2000 Federal Poverty Income Guidelines*

| *Family Size* | *133%* | *150%* | *200%* |
|---|---|---|---|
| 1 | $926 | $1044 | $1,392 |
| 2 | $1,247 | $1,407 | $1,875 |
| 3 | $1,569 | $1,769 | $2,359 |
| 4 | $1,890 | $2,132 | $2,842 |
| 5 | $2,212 | $2,494 | $3,325 |
| 6 | $2,533 | $2,875 | $3,809 |
| 7 | $2,854 | $3,219 | $4,292 |
| 8 | $3,176 | $3,582 | $4,775 |
| Each additional person | Add $322 | Add $363 | Add $484 |

DMA updates the federal poverty income guidelines each April based on changes made by the federal government. The income levels above reflect the standards as of April 1, 2000.

*B. Division of Health Care Finance and Policy - Annual Income Guidelines*
*2000 Federal Poverty Income Guidelines for the Uncompensated Care Pool*

*1999 Federal Poverty Income Guidelines*

| *Family Size* | *200%* | *400%* |
|---|---|---|
| 1 | $16,700 | $33,400 |
| 2 | $22,500 | $45,000 |
| 3 | $28,300 | $56,600 |
| 4 | $34,100 | $68,200 |
| 5 | $39,900 | $79,800 |
| 6 | $45,700 | $91,400 |
| 7 | $51,500 | $103,000 |
| 8 | $57,300 | $114,600 |
| Each additional person | Add $5,800 | Add $11,600 |

The Division updates these guidelines annually each spring based on changes made by the federal government. The income levels above reflect the standards as of February 15, 2000.

## Appendix III: Legislative and Administrative History

The Children's Medical Security Plan (CMSP) was initially conceptualized as a health care program that would provide preventive pediatric health care services to children not covered by Medicaid or private insurance.

In the nine years since the original authorizing legislation, CMSP has evolved from a pilot program providing limited preventive services to children ages birth to under age six into a managed care program providing a variety of outpatient and limited inpatient services to all eligible children up to and including the age of 18. The following legislative and administrative history of CMSP illustrates some of the factors that have had to be balanced over the life of the program. Given fixed appropriations, at different points in time, either the numbers of children enrolled in the program or the benefits offered have had to be restricted.

### *Chapter 495 of the Acts of 1991*

A program offering basic preventive and sickness care was initially authorized in 1991 under Chapter 495 of the Acts of 1991. The program was intended only for children up to the age of 6. The benefits provided for in the legislation were limited to preventive pediatric health care services and screening for lead poisoning. The concept of managed care was not referred to in the legislation. The premium for people between 200% and 400% FPL was set at 40% of the full premium, a much higher level than currently required of the same income group. As the result of this legislation, in 1993, $5 million was appropriated to pilot a one-year program known as Healthy Kids. At that time it was estimated that one half of the 55,600 uninsured children under the age of 6 would be eligible.[20]

### *Chapter 110 of the Acts of 1993*

Chapter 110, the FY94 budget, established a managed health care program of primary and preventive health care for uninsured children from age 6 through 12.
This legislation reflected a general concern that costs be contained. To this end the legislation required that services provided be medically necessary and that the program be set up as a managed care program. Nine benefits were specifically mandated by the legislation.[21] Benefits included a mental health benefit of up to 26 visits a year as well as routine eye exams.

### *Chapter 393 of the Acts of 1993*

Chapter 393, enacted late in 1993, combined the two programs by including children from birth to age 6 in the more expanded program established by Chapter 110. Unlike the prior programs, the cost of premiums and co-payments was not legislated. Instead fees were to be set administratively by the Department of Medical Security (DMS).

The new expanded program was implemented in July 1994 as the CMSP program. DMS set the premium at $25/month per child for families with incomes between 200% and 400% FPL. The full cost of the premium for families with incomes over 400% was $66 to $75 a month. The program was designed to serve up to 16,000 children and had an appropriation of $12 million. Estimates at that time put the number of children eligible for the program at between 60,000 and 90,000[22] children. By December 1994 enrollment was 22,600. Governor Weld closed the program to new enrollees and began a waiting list. The Weld administration projected that it would cost $18.6 million to provide coverage to all the children already enrolled. Consumer activists contended that there was no evidence to suggest that the plan would exceed the appropriated amount. Nine months later in October 1995, the plan reopened enrollment. According to newspaper accounts of the time, the four thousand children on the waiting list were either found eligible for Medicaid or brought into the plan.[23] Total expenditures for FY95 came to $9,927,647.

*Chapter 60 of the Acts of 1994*

Chapter 60, the FY95 budget, fine-tuned and expanded upon the 1993 cost containment measures. The first change made by the legislature was to divide all previously mandatory benefits into two categories – mandatory and optional. Preventive care, unlimited sick visits, first-aid treatment and provision of smoking prevention educational information were classified as mandatory. All other benefits were optional. By choosing to make some benefits optional, the legislature gave the administering department the ability to restrict or expand the actual benefits provided according to both the amount of total dollars appropriated and the actual number of children enrolled. Before this provision was passed, the only option available to administrators, given a set appropriation, was to restrict enrollment. Now if enrollment was high, they could choose to either restrict enrollment or reduce benefits. Alternatively, if enrollment was low, benefits could be increased.

Second, changes were made directly to certain benefits to encourage cost containment. The mental health benefit was reduced from a maximum of 26 visits a year to a maximum of 13 visits a year. The eye exam benefit was changed from a once a year routine benefit to a medically necessary visit.

Third, the legislation set parameters for premium charges. The premium amounts were reduced so that families between 200% and 400% FPL paid only 20-30% of the full premium cost with a premium limit equal to the cost of three children per family. Families over 400% FPL continued to pay the full premium cost.

Fourth, co-payments were required of all participants, even the poorest, in an effort “to encourage the cost-effective and cost conscious use of said services.” A philosophical debate exists over whether minimal co-payments to ensure responsibility is worth the administrative cost of collecting and accounting for the co-payments. The legislature clearly indicated its position when it included this provision in the law.

*Chapters 151 and 203 of the Acts of 1996*

In 1996 two new pieces of legislation were passed—Chapter 151 of the Acts of 1996 and Chapter 203 of the Acts of 1996.

Chapter 151, the FY97 budget, moved responsibility for administering CMSP from DMS to DPH.

Chapter 203, enacted in August 1996, expanded coverage of children from ages 0-12 to ages 0-18. This Act was passed in response to pressure from advocates of uninsured teenagers. According to the Current Population Survey there were approximately 36,000 children ages 13-18 eligible for CMSP.[24]

*Chapter 170 of the Acts of 1997*

Chapter 170 of the Acts of 1997 was the most recent piece of legislation to impact CMSP. One significant change enacted by this legislation was the requirement that only youths found to be ineligible for MassHealth could qualify and enroll in CMSP. Until this time youth were encouraged to apply for MassHealth but not required to enroll, even if eligible.

Important changes were also made to the optional benefits section of the legislation. Three new optional benefits were added: primary and preventive dental care; durable medical equipment was increased from $200 a year to $500 a year for conditions related to diabetes, asthma and seizure disorders; and auditory screening. One current benefit—the prescription drug benefit—was increased from $100 to $200 a year. Two benefits were partially restored to previous benefit levels offered: the mental health benefit allows an additional 7 visits (up to a maximum of 20) if determined to be clinically necessary, and the eye exam benefit was changed to allow for both medically necessary and annual visits. Even though the Chapter 170 changes were effective July 1, 1998, only the auditory screening and the expanded eye exam benefit were implemented. Because of budgetary constraints, the other additional, optional benefits were not implemented until recently.

## Endnotes

[1] Outpatient surgery is primarily for hernias and eartubes.

[2] For certain services, CMSP pays providers Medicare RBRVS (Resource Based Relative Value Scale) rates adjusted by the Massachusetts Urban Geographic Practice Cost Index (GPCI). For other services CMSP pays according to rates established by the Division of Health Care Finance and Policy.

[3] Enrollment data for June 1997, September 1997 and December 1997 was provided by DPH and includes enrollment in CMSP programs administered by both Unicare and CHP. Enrollment data from March 1998 to March 2000 is from Unicare's Monthly Enrollment and Fiscal Reports.

[4] For more information on MassHealth expansion see: (1) Commonwealth of Massachusetts Title XXI Children's Health Insurance Program Annual Report, Prepared for the Division of Medical Assistance by the Center for MassHealth Evaluation and Research, April 1999; (2) MassHealth Title XXI State Plan, Division of Medical Assistance; (3) MassHealth 1115 Demonstration Project Budget Neutrality Analysis - A Guidebook to the Mercer Assumptions, February 1999, Prepared by the Center for MassHealth Evaluation (CMER) in collaboration with the Division of Medical Assistance.

[5] Data from Unicare's Monthly Enrollment and Fiscal Reports.

[6] This figure provided in a conversation with the director of CMSP.

[7] The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and the federal Balanced Budget Act of 1997 restrict the eligibility of immigrants for publicly funded benefits. Some immigrants are concerned about the “public charge” issue. The U.S. Government's “guidance” effective May 25, 1999 stated that use of public health benefits would not make an immigrant a public charge unless it was for long term care services. For more information on the public charge issue see www.hcfa.org/immigrant.

[8] Data from Unicare's Monthly Demographic Reports for both permanent and 45 day enrollees.

[9] Data from Unicare's Monthly Demographic Reports for permanent enrollees only.

[10] Data from Unicare's Monthly Demographic Reports by Family for permanent enrollees only.

[11] Data from Unicare's Monthly Claims Reports (FY97) and from electronic data provided by Unicare (FY98 and FY99)

[12] Data from Unicare's Monthly Claims Reports (FY97) and from electronic data provided by Unicare (FY98 and FY99)

[13] Table provided by CMSP staff, Department of Public Health (DPH).

[14] Data from Unicare's Monthly Premium Reports. For readers interested in understanding how premium cost affects an individual's decision to purchase insurance the following articles are recommended: The Use of Sliding Scale Premiums in Subsidized Insurance Program, Leighton Ku and Teresa A. Coughlin. The Urban Institute, March 1997; Exploring the Determinants of Employer Health Insurance Coverage, Prepared for the AFL-CIO, John F. Shiels, Paul Hogan, Nikolay Massalov, PhD, The Lewin Group, January 20, 1998.

[15] PMPM costs provided by DPH.

[16] The per member per month costs may be underestimated. Over the last two years, CMSP has focused much of its administrative efforts in coordinating the transfer of children from CMSP to MassHealth. While children were never dually enrolled in both CMSP and MassHealth, it is evident that many remain nominally enrolled in CMSP while awaiting final MassHealth determination, thus increasing the average monthly enrollment figure and making PMPM costs appear lower than they actually are. A variety of other factors including provider

billing of other, better paying sources for services, the automatic enrollment of families with incomes over 200% FPL for a period of time regardless of whether they actually intend to participate, and the automatic enrollment of children for a period of time mistakenly thought to have family incomes under 200% FPL result in overstating the number of active enrollees and underestimating the per member per month costs.

[17] Amount listed in DPH contract with Unicare.

[18] See endnote # 7.

[19] Massachusetts General Laws - Chapter 111, Section 24G.

[20] *Health Plans Arise for Young*, Boston Globe, November 25, 1992.

[21] The 9 mandated benefits were preventive pediatric care, unlimited sick visits, emergency care (including related laboratory and diagnostic radiology services), first aid treatment and follow-up, outpatient surgery and anesthesia for hernia and ear tubes, outpatient mental health services, prescription drugs, smoking education and eye exams.

[22] *Freeze on Children's Health Plan Assailed at State House Hearing*, Boston Globe, January 13, 1995. *Cheating on Children*, Boston Globe, March 13, 1995. Also, data from merged March 1993 and March 1994 Current Population Survey in Chapter 203 Budget Neutrality Report, Division of Medical Assistance.

[23] *Health Care Program for Poor Children is Reopened to Applicants*, Boston Globe, October 3, 1995.

[24] Data from merged March 1993 and March 1994 Current Population Survey in Chapter 203 Budget Neutrality Report, Division of Medical Assistance.